



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DAVID V. DENT, M.D.
5501-A BALCONES DR, #310
AUSTIN, TX 78731

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-12-0111-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary from Table of Disputed Services: "Claim was sent on 1/21/11 with no response second request was sent with proof of timely filing sent on 7/21/11- claims denied on 7/29/11 for past timely filing. Called ins. co. they said they wont [sic] accept our proof that claims were sent on time."

Amount in Dispute: \$857.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response.

Response Submitted by: N/A

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|---|-------------------|------------|
| January 5, 2011 | 99213-25, 99080, 95851-59, G0431-GW, G0431-QW-59 | \$857.15 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

5. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
6. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
7. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 29, 2011

- 29-The time limit for filing has expired.
- 17-Payment adjusted because requested information was not provided or was insufficient/complete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
- 97-Payment is included in the allowance for another service/procedure.
- 50-These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 73-TWCC 73 report form.
- Per Rule 133.20; A health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. *The providers claims history report is not sufficient proof of filing accepted by the carrier. *Incomplete DWC 73; Sections II and/or III must be completed for proper review. Documentation does not support the use of -59 modifier for separate payment for multiple RX/Drug screen.

Issues

1. Is CPT code G0431-QW-59 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
2. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
3. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there is an unresolved issue of medical necessity for CPT code G0431-QW-59 for which there is a medical fee dispute. No documentation was submitted to support that the issue of medical necessity has been resolved prior to the filing of the request for medical fee dispute resolution. The requestor has failed to support that CPT code G0431-QW-59 is eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.
2. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor code §408.0272...a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute. For that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
3. Review of the documentation submitted by the requestor finds a copy of a medical bill with printed date

07/21/11 in box 31, a Claims Filed History Report, and an Explanation of Benefits dated July 29, 2011. No documentation was found per 28 Texas Administrative Code §102.4(h) to sufficiently support that the requestor submitted a bill to the insurance carrier within 95 days from the date the services were provided to the injured employee.

4. In accordance with Texas Labor Code §408.027, the Requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the service in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

| | | |
|--------------------|---|--------------------|
| _____ Signature | _____ Medical Fee Dispute Resolution Officer | 01/30/2012 Date |
|--------------------|---|--------------------|

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.